1.0 Description of the Service

Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology and occupational therapy), home health aide services, and medical supplies provided to recipients who reside in private residences. Skilled nursing, specialized therapies and medical supplies can also be provided if the recipient resides in an adult care home (such as a rest home or family care home).

Descriptions of the services available under the Medicaid home health program are listed below. All services must be provided by staff employed by or under contract to the home health agency.

1.1 Skilled Nursing

Skilled nursing is the assessment, judgment, intervention, and evaluation of interventions that require the training and experience of a licensed nurse.

Skilled nursing services are covered when furnished by a registered nurse (RN) or a licensed practical nurse (LPN).

Services must be medically reasonable and necessary for the diagnoses and to the treatment of the recipient's illness or injury. The services include:

- observation, assessment and evaluation of the recipient's condition when only the specialized skills and training of a licensed nurse can determine the recipient's medical status
- management and evaluation of the recipient's plan of care (POC) to ensure that the care is achieving its purpose
- teaching and training the recipient, the recipient's family or other caregivers how to manage the recipient's treatment regimen
- skilled nursing procedures medically reasonable and necessary for the treatment of the recipient's illness or injury

1.2 Specialized Therapies

1.2.1 Physical Therapy

Physical therapy services are covered when provided by a licensed physical therapist (PT) or by a licensed physical therapy assistant under the direction of a licensed PT. These services help relieve pain, restore maximum body function, and prevent disability following disease, injury or loss to a part of the body.

1.2.3 Speech Therapy

Speech/language pathology services are covered when provided by a licensed speech/language pathologist to treat speech and language disorders that result in communication disabilities. The services are also provided to treat swallowing disorders (dysphagia), regardless of the presence of a communication disability.

1.2.4 Occupational Therapy

Occupational therapy services are covered when provided by a licensed occupational therapist (OT) or by a licensed occupational therapy assistant under the direction of a licensed OT. Services help improve and restore functions impaired by illness or injury. When a recipient's functions are permanently lost or reduced, occupational therapy helps improve the recipient's ability to perform the tasks needed for independent living

1.3 Home Health Aide Services

Home health aide services are paraprofessional services provided by a Nursing Aide I or II (NA I or NA II) to support or assist the skilled service (skilled nursing and specialized therapies) being provided.

Home health aide services help maintain a recipient's health and facilitate treatment of the recipient's illness or injury. Typical tasks include:

- assisting with activities of daily living (bathing, caring for hair and teeth, eating, exercising, transferring and elimination assistance)
- assisting a recipient in taking self-administered medications that do not require the skills of a licensed nurse to be provided safely and effectively
- assisting with home maintenance that is incidental to a recipient's medical care needs, such as light cleaning, meal preparation, taking out trash and grocery shopping
- performing simple medical duties such as taking a recipient's temperature, pulse, respiration, and blood pressure; weighing the recipient; changing dressings that do not require the skills of a licensed nurse; and reporting changes in the recipient's condition and needs to appropriate health care professional

1.4 Medical Supplies

Medical supplies include those items listed on the *Home Health Maximum Reimbursement Rate Schedule*. This list is available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their Medicaid coverage category or living arrangement that may limit the services available to them or make them ineligible for the service. The home health agency providing services is required to verify the recipient's eligibility, Medicaid coverage category, other insurance coverage, and living arrangement before initiating services.

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

2.3 Medicaid Identification Cards

Individuals approved for Medicaid receive a monthly MID card as proof of their eligibility. The color of the MID card indicates eligibility coverage and restrictions that apply to the recipient.

2.3.1 Blue Medicaid Card

Recipients with a blue MID card are eligible for home health services.

2.3.2 Pink Medicaid Card - Medicaid for Pregnant Women (MPW)

Pregnant women with a pink MID card are eligible for home health services if the service is required for a pregnancy-related condition. Home Health services for these recipients must be prior approved. Refer to sections 2 and 6 of the *Basic Medicaid Billing Guide* on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for additional information on Medicaid eligibility and for guidance on prior approval.

2.3.3 Buff Medicaid Card - Medicare Qualified Beneficiary (MQB)

Medicaid recipients with a buff MQB card are not eligible for Medicaid covered home health services.

2.4 Managed Care Participation

The MID card indicates if the recipient is enrolled in a managed care program under Medicaid. Recipients participating in a managed care program, including Medicaid health maintenance organizations and Community Care of North Carolina programs (Carolina ACCESS and ACCESS II/III), must access home health services through their primary care physician.

3.0 When the Service is Covered

3.1. General Criteria for Medical Necessity

Home health services must be medically necessary for the treatment of a recipient's illness, injury or medical condition as documented by the physician who orders the service.

3.2 General Criteria for Providing Services in the Home

The home health agency must be able to provide the services safely and effectively in the recipient's home in accordance with Division of Facility Services (DFS) Home Care Licensure Rules and the home health agency's policy.

3.2.1 Home Health Visits

Nursing, home health aide, and therapy services are provided on a per visit basis. The home must be the most appropriate setting for the service. Home health services are deemed appropriate when the recipient's medical records include documentation supporting one or more of the following reasons why the services should be provided in the recipient's home instead of the physician's office, clinic or other outpatient setting.

1. The recipient requires assistance in leaving the home, such as with opening doors and other routine activities.

2. The recipient is non-ambulatory or wheelchair bound with a medical condition that precludes leaving home on a regular basis.
3. The recipient would require ambulance transportation.
4. The recipient is medically fragile or unstable:
   - infants up to six weeks of age with acute needs and/or who are at medical risk
   - post-surgery recipients who are restricted from activity except for short periods of time
   - recipients with a medical condition that would likely be exacerbated by leaving the home
   - recipients with a medical condition that would make leaving home inadvisable or detrimental to the recipient's health
   - recipients who are experiencing severe pain
   - recipients with shortness of breath that significantly hinders travel
   - recipients who, because of their medical condition, must be protected from exposure to infections
   - recipients who have just had major surgery
5. Leaving the home would interfere with the effectiveness of the services:
   - recipients with an extreme fear of the hospital or physician's office, especially young children
   - recipients living in an area where travel time to outpatient services would require one-hour or more of driving time
   - recipients who need a service repeated at frequencies that would be difficult to accommodate in the physician's office, clinic or other outpatient setting
   - recipients requiring regular and PRN (as needed) catheter changes
   - recipients who have demonstrated a failure to comply with medical appointments at a physician's office, clinic or other outpatient facility due to a medical condition or cognitive impairment and have suffered adverse consequences as a result
   - recipients requiring complex wound care such as irrigation and packing twice a day or more.
   - recipients requiring assistive devices specifically customized for their home environment (bath chairs, shower grab bars, etc.)

3.2.2 Medical Supplies

Medical supplies must be medically necessary and reasonable for use in the home, included in the recipient's plan of care (POC) and listed on the *Home Health Maximum Reimbursement Rate Schedule*.

3.3 Skilled Nursing Services

A Medicaid eligible recipient qualifies for in-home skilled nursing services when he/she meets the criteria listed in **Section 3.1** and **Section 3.2** and all the following requirements are met:

1. The services are ordered by the recipient's attending physician and provided according to an approved POC.
2. The recipient requires medically necessary skilled nursing care that can only be provided by a licensed RN or LPN.
3. The recipient requires repeated skilled nursing assessments and ongoing monitoring that can be provided on an intermittent or part-time basis.
4. The recipient resides in a private residence, an adult care home or a group home.

3.4 Specialized Therapy Services

A Medicaid eligible recipient qualifies for in-home specialized therapy (physical therapy, occupational therapy, and speech/language therapy) assessment and evaluation and treatment services when he/she meets the general criteria listed in **Section 3.1** and **Section 3.2.** The recipient may reside in a private residence, an adult care home or a group home.

Refer to **Attachment B, Home Health Outpatient Specialized Therapies Guidelines** for information on prior approval for specialized therapies.

Refer to **Attachment C, Medicare-Medicaid Skilled Services Billing Guide** for information on billing therapy visits.

Refer to Clinical Coverage Policy # 10A, Outpatient Specialized Therapies, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for additional information.

3.5 Home Health Aide Services

An eligible Medicaid recipient qualifies for home health aide services when he/she meets the criteria listed in **Section 3.1** and **Section 3.2** and all of the following requirements are met: The service is ordered by the recipient's attending physician and delivered according to a POC that is established by the nurse or licensed therapist and authorized by the attending physician.

1. The recipient requires help with personal care, activities of daily living, and/or non-skilled health care.
2. The service is provided under the professional supervision of an RN or licensed therapist in accordance with the federal conditions of participation.
3. The recipient resides in a private residence.
4. The recipient must be receiving a skilled service (skilled nursing or specialized therapies) to qualify for these services.
5. The tasks performed by the home health aide are those specified in the POC. The task must be within the scope of home care licensure rules as set forth by the N.C. Board of Nursing (NCBON).

3.6 Medical Supplies

Medical supplies are covered when the supplies are ordered by a physician, documented in the recipient's plan of care, and are medically necessary as part of the recipient's home health care. The supplies may be furnished to any eligible Medicaid recipient as long as these criteria are met even if no other skilled services are rendered.

3.6.1 Coverage Criteria

An item is covered when it meets the following criteria:

1. The item supplied is medically reasonable and necessary for treatment of a recipient's illness or injury.
2. The item supplied has a therapeutic or diagnostic purpose for a specific recipient and is not a convenience or comfort item (items that are often used by persons who are not ill or injured, such as soaps, shampoos, lotions and skin conditioners).
3. The item supplied must be specifically ordered by the physician and included in the POC. The physician's order in itself does not make an item "medically necessary" in the context of Medicaid coverage. The order authorizes you to provide the item but it should be billed to Medicaid only if it meets Medicaid criteria.
4. The item supplied is not an item routinely furnished as part of recipient care (minor medical and surgical supplies routinely used in recipient care such as alcohol wipes, applicators, lubricants, thermometers, and thermometer covers are not billed individually to Medicaid). These items are considered part of an agency's overhead costs and cannot be reimbursed as separate items.
5. The item supplied is one considered a home health medical item by Medicaid. Items such as drugs and biologicals, medical equipment, orthotics and prosthetics, and nutritional supplements are examples of items not considered home health medical supplies.
6. Assessment of the need of the supply, and the appropriateness of the item supplied, is determined by a RN at least every 60 days through an in-home assessment.
7. When incontinence supplies are being provided and the only service being rendered involves physical or occupational therapy, the assessment for incontinence supplies can be conducted by the therapist.

3.6.2 Use of Miscellaneous Procedure Codes

The *Home Health Maximum Reimbursement Rate Schedule* lists the covered medical supplies with the applicable national HCPCS code. The fee schedule is posted on DMA's website (http://www.dhhs.state.nc.us/dma/fee/fee.htm) and lists covered supplies by HCPCS code as mandated under the Health Insurance Portability and Accountability Act (HIPAA). Periodic updates are made to the fee schedule to accommodate coding changes made by the Centers for Medicare and Medicaid Services (CMS). Every effort is made to include the items that are medically necessary and reasonable to treat the illness, diseases or injuries common to the Medicaid home care population. Provisions are made to allow billing and reimbursement for items that are medically necessary for treatment but not included on the fee schedule through using miscellaneous procedure codes. The miscellaneous code used must be on the fee schedule and the supply must meet Medicaid's coverage criteria.

When considering the use of a miscellaneous procedure code:

1. Determine whether the item is not elsewhere classified (listed under another Medicaid program). If the supply is on the Durable Medical Equipment (DME) fee schedule or the Home Infusion Therapy (HIT) fee schedule, but is not listed on the *Home Health Maximum Reimbursement Rate Schedule,* the item is not covered as a home health medical supply.
2. Determine whether the item meets the medical necessity criteria outlined in **Section 3.6.1**.

3. Document the medical reason necessitating the use of this item instead of one listed on the fee schedule. Retain this information in the recipient's medical records.

Note: If the medical supply item is not listed on the fee schedule but will need to be used on a continuous basis, a request to add the item should be submitted to DMA. The request must be submitted on the **Request for Medicaid Coverage – New Home Health Supply form** (form A001) with supporting documentation on cost, usage, and efficacy. Refer to **Attachment D, Request for Medicaid Coverage of New Home Health Supply** for additional information and a copy of the form.

4.0 When the Service is Not Covered

Home health services are not covered unless eligibility criteria listed in **Section 2.0** and medical necessity criteria listed in **Section 3.0** are met. Home health services are also not covered in the following situations:

1. Home health aide services for recipients residing in an adult care or group home.
2. When no skilled service is being provided.
3. Provision of maintenance occupational therapy services.
4. Medical supply items routinely furnished as part of recipient care such as alcohol wipes, applicators, lubricants or thermometers.
5. When the service duplicates another provider's service.
6. When the service is experimental, investigational, or part of a clinical trial.
7. When the recipient does not have a qualifying condition requiring additional effort or support to leave the home (see **Section 3.2**). The following conditions offer examples that do not justify provision of the care in the home:
   - a wheelchair-bound recipient who regularly drives a specially equipped vehicle to travel outside of the home without another qualifying condition
   - routine transportation or assistance with transportation to medical appointments since medical transportation is available through county departments of social services
8. When home health aide services are provided on the same day as Personal Care Services (PCS).
9. When the services rendered were not ordered by a physician and included on the authorized POC.
10. Home health services related to the terminal illness when the recipient has elected Medicare or Medicaid hospice benefits. Home health services can be provided when they are unrelated to the terminal illness.

Note: The Transfer of Assets policy applies to the eligibility for Medicaid reimbursement of long-term care and home care services for certain Medicaid recipients**.** A Transfer of Assets evaluation must be made by the local county department of social services (DSS) prior to Medicaid reimbursement of any of these services. Refer to Family and Children's Medicaid Eligibility Manual, Section MA-2240, *Transfer of Resources*, on DMA's website at http://www.dhhs.state.nc.us/dma/publications.htm for further guidance.

Note: Medicaid hospice participation and transfer of asset status can be accessed through the Automated Voice Response (AVR) system. Refer to Section 2 and Appendix A of the *Basic Medicaid Billing Guide* on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for information on recipient eligibility and for instructions on using the AVR system.

5.0 Requirements for and Limitations on Coverage

5.1 Documenting the Plan of Care

The recipient's attending physician must order all home health services and sign a POC submitted by the agency on form CMS-485. The physician's stamped signature is acceptable on the form in accordance with DFS policy and CMS regulations. The physician must reauthorize the POC every 60 days.

5.1.1 Authorizing Services

With verbal authorization from the physician, the home health agency can begin services prior to receiving written orders. Verbal orders must be documented and signed by the physician according to home care licensure rules.

5.1.2 Developing the Plan of Care

The POC is developed by the home health nurse or therapist in collaboration with the physician and according to home care licensure rules and federal conditions of participation. The documentation must indicate that all ordered services are medically necessary and the recipient's home is the most appropriate setting for the care.

5.1.3 Components of the Plan of Care

The POC must include:

1. all pertinent diagnoses, including the recipient's mental status
2. the type of services, supplies, and equipment ordered
3. the frequency and duration of visits for skilled nursing, therapy, and home health aide services
4. the recipient's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments
5. a statement that the recipient's home is the most appropriate setting for the required services
6. safety measures to protect against injury
7. discharge plans

5.1.4 Changing the Plan of Care

The physician must authorize any change in the amount, type or frequency of home health services provided. The physician's orders may be verbal or written. Verbal orders must be transcribed and signed by the physician in accordance with Home Care Licensure Rules.

5.1.5 Documenting Specialized Therapy Treatment Services

The process for documenting the POC for specialized therapy treatment services must follow the steps and requirements listed in **Attachment B, Home Health Outpatient Specialized Therapies Guidelines**.

Note: Home care licensure rules provide guidelines for acceptance of electronic signatures on documentation.

5.2 Specialized Therapies

The Medicaid Home Health Program covers physical therapy, speech therapy, and occupational therapy.

5.3 Prior Approval

Prior approval for home health services is required in the following instances.

5.3.1 Medicaid for Pregnant Women

Prior approval is required for home health services for pregnant women with MPW coverage. Prior approval requests are submitted in writing to the Medicaid fiscal agent on a Request for Prior Approval North Carolina Medicaid Program form (372-118).

5.3.2 Prior Approval for Outpatient Specialized Therapies

Prior approval is required after the initial evaluation visit and six therapeutic visits of the same type or discipline. The six-visit limit is per provider type per lifetime. Any additional therapy after the initial six treatments visits requires prior approval regardless of time lapse or change in home health agency. Refer to **Attachment B, Home Health Outpatient Specialized Therapies Guidelines** for information on this process.

The Medicaid program contracts with Medical Review of N.C. (MRNC) to perform the prior approval process for outpatient specialized therapies. It is recommended that a prior approval request be submitted following completion of the evaluation visit.

A completed and signed **Prior Authorization Request for Outpatient Specialized Therapy Services** form and required documents must be faxed to MRNC at 800-228-1437 for treatment to be continued. If appropriate, MRNC will authorize services for a specific number of units through a specific length of time. Units should be requested based on the visit code to be billed. Refer to the MRNC website at http://www.mrnc.org for copies of the prior approval request form and additional information.

5.4 Location of Service

5.4.1 Private Residence

Skilled nursing services, specialized therapy services, and home health aide services can be provided to recipients in a private residence.

5.4.2 Adult Care Homes and Group Homes

Skilled nursing services, medical supplies, and specialized therapy services can also be provided in the adult care and group home setting.

Note: Home health aide services are not covered for recipients residing in adult care or group homes.

5.5 Amount, Frequency, and Duration of Service

Home health services are provided through visits made to the recipient's home by the skilled staff or a home health aide. Home health visits are provided as follows:

1. A visit begins when a service is initiated and does not end until the delivery of the service is completed.
2. If multiple services are required and can be performed during the same visit, then all the services should be completed in only one visit.

5.5.1 Skilled Nursing

Skilled nursing are provided under the N.C. Medicaid program on a per visit basis. Skilled nursing visits are limited to the amount, frequency, and duration of service ordered by the physician and documented in the POC. The visits must be provided on an intermittent or part-time basis.

Part-time means:

1. Skilled nursing visits and/or home health aide visits can be provided at anytime, during a 24-hour period, seven days per week.
2. The total time spent per week in skilled nursing visits and home health aide visits cannot exceed eight hours per day and 34 hours per week.

Intermittent means either:

1. Skilled nursing visits and/or home health aide visits are not made each day of the week and the total time spent in those visits in a week is 34 hours or less; **or**
2. Skilled nursing visits and/or home health aide visits are made each day of the week but the time spent for the visits each day is less than eight hours.

5.5.2 Scope of Skilled Nursing Services

Skilled nursing must be provided in accordance with a physician-approved POC and within the scope of Home Care Licensure Rules and N.C. Board of Nursing (NCBON) Nurse Practice Act.

5.5.3 Specialized Therapies

The type, amount, frequency, and duration of specialized therapy treatment visits are limited to what is ordered by the physician and documented in the POC. Specialized therapy treatment is subject to the limits and requirements and prior approval process listed in **Attachment B, Home Health Outpatient Specialized Therapies Guidelines** of this policy.

5.5.4 Home Health Aide Services

Home health aide services are limited to the amount, frequency, and duration of service ordered by the physician and documented in the POC. Home health aide services are provided only in the recipient's private residence.

6.0 Providers Eligible to Bill for the Service

To qualify for enrollment as a Medicaid home health provider, the agency must be Medicare-certified and licensed by DFS to provide home health services. All services shall be provided by staff employed by or under contract to the home health agency.

6.1 Provision of Service

Skilled nursing care must be provided by a RN or a LPN. Skilled nursing care must be supervised by a RN. The services shall be provided within the scope of practice, as defined by the NCBON Nurse Practice Act and Home Care Licensure Rules.

All services provided by a home health aide must be supervised by an RN or a licensed therapist. Supervisory visits must be made at least once every two weeks in accordance with the federal conditions of participation

Specialized therapy services must be provided by the appropriate licensed therapist or a qualified therapy assistant under the direction of a licensed therapist.

6.2 Home Health Aide Services

1. NA I and II training, qualifications, and tasks must meet NCBON standards.
2. The aide must be listed as a Nurse Aide I on the NA Registry at the N.C. Department of Health and Human Services, DFS, or listed as a Nurse Aide II on the NCBON registry.

7.0 Additional Requirements

7.1 Utilization Review for Specialized Therapy Services

Medicaid or MRNC, or agents acting on behalf of Medicaid, may perform reviews for monitoring utilization, quality, and appropriateness of services rendered. These reviews may include, but are not limited to:

- focused reviews of established criteria for service provision
- reviews of prior approved services
- post-payment reviews

7.2 Coordination of Home Care Services

The home health agency is responsible for determining what other services the recipient is receiving and for coordinating care to ensure there is no duplication of service.

7.2.1 Coordination with Private Duty Nursing

Home health skilled nursing services cannot be provided at the same time as Private Duty Nursing (PDN) services. Home health services can be provided for care or treatment of the recipient outside the hours covered by PDN. This includes making an assessment for medical supplies when medical supplies are not the only service being provided by the home health agency.

If medical supplies are the only home health service needed by the PDN recipient, then the PDN provider should assume responsibility for this service and bill Medicaid for the supplies as part of the PDN service.

Specialized therapies may be provided during the same time period that a recipient is receiving PDN services.

Home health aide services may not be provided on the same day or during the same hours a recipient is receiving PDN services.

7.2.2 Coordination with In-Home Drug Therapy

Home health services may be covered for medical needs not related to the provision of drug therapy if the recipient is receiving services from a Home Infusion Therapy (HIT) provider. Home health visits should be coordinated with other medical providers to avoid more than one person working with the recipient at the same time.

7.2.3 Coordination with In-home Nutrition Therapy

Skilled nursing care may be provided to recipients receiving enteral or parenteral nutrition therapy. DME suppliers and HIT providers may furnish the equipment, supplies, and formulae needed for enteral nutrition. However, only HIT providers may provide these items for parenteral nutrition.

7.2.4 Coordination with Hospice

Hospice provides all skilled nursing care related to the terminal illness. Only home health services not related to the terminal illness may be provided to a hospice recipient.

7.2.5 Coordination with Community Alternatives Programs

If a recipient is eligible under one of the Community Alternatives Programs (CAP), including CAP/DA, CAP/C, CAP/MR-DD or CAP-AIDS, the home health agency must coordinate services with the responsible CAP case manager.

CAP case managers are responsible for keeping the cost of home care services within the limits of the CAP program being utilized.

7.3 Medical Record Documentation

The home health agency is responsible for maintaining all financial and medical records and documents necessary to disclose the nature and extent of services billed to Medicaid.

These records must be maintained:

1. at the home health agency office responsible for providing services to the recipient except for financial records which may be maintained in a central location and made available to DMA upon request
2. in an accessible location and in a manner that will facilitate regulatory review
3. for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state regulations or agreements

Upon request, the home health agency will provide to Medicaid all financial and medical records for recipients whose care and treatment has been billed in whole or in part to Medicaid.

8.0 Policy Implementation/Revision Information

Original Effective Date: February 1, 1980

Revision Information:

Date	Section Revised	Change
9/1/05	Section 2.2	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.

Attachment A: Claims Related Information

A. Claim Type

Home health services are billed on a UB-92 claim form. Refer to Section 5 of the *Basic Medicaid Billing Guide* on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for information on completing the UB-92 claim form.

B. Diagnosis Codes that Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis code(s) that most accurately describe the recipient's illness, injury or medical condition. The diagnosis code(s) must be as comprehensive, detailed, and specific as possible.

C. Billing for Service

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

The home health agency furnishing the service must bill for services with their individual Medicaid provider number.

1. What May Be Billed

a. Providers may bill for services ordered by a physician and documented in the recipient's individual POC.

b. Individual home health services must be billed in accordance with Medicaid billing policies and procedures.

c. Supervisory visits are considered administrative costs and may not be billed as skilled nursing services.

2. Billing Codes

The revenue codes used for billing home health skilled visits, home health aide visits, and specialized therapies are listed in the table below. Refer to **Attachment C, Medicare-Medicaid Skilled Services Billing Guide** for additional billing information.

Code	Description	Unit of Service
RC420	Physical therapy	1 Visit
RC430	Occupational therapy	1 Visit
RC440	Speech-language pathology services	1 Visit
RC424	Physical therapy evaluation	1 Visit
RC434	Occupational therapy evaluation	1 Visit
RC444	Speech-language pathology services evaluation	1 Visit
RC550	Skilled nursing-gen class	1 Visit
RC551	Skilled nursing visit/ prefilling insulin syringes	1 Visit
RC559	Skilled nursing visit/ prefilling med dispensers	1 Visit
RC580	Skilled nursing visit/meeting Medicare criteria	1 Visit
RC581	Other visits-home health-visit charge/ visit denied by Medicare for a dually eligible recipient	1 Visit
RC589	Other visits-home health-other	1 Visit
RC590	Units of service (home health) general classification	1 Visit
RC570	Home health aide	1 Visit

Home health medical supplies are billed using revenue code 270, along with the HCPCS code for the individual supply.

D. Providers must bill their usual and customary charges. The maximum allowable rate is based on the Home Health Maximum Reimbursement Rate Schedule, which is available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

Attachment B: Home Health Outpatient Specialized Therapies Guidelines

Medicaid requires prior approval for all therapy services provided on an outpatient basis after the initial evaluation visit and six treatment visits (per recipient, per discipline, per provider category, per lifetime). The Medicaid Home Health Program covers the following therapies; speech therapy; physical therapy and occupational therapy. The guidelines listed below should be followed when these services are provided.

I. Prior Approval Guidelines

The following describes how the prior approval requirements apply to therapies under home health services.

1. Prior approval is required for all home health therapy treatment visits after the initial six treatment visits per recipient per discipline, per lifetime, per provider category regardless of the number of agencies who have provided therapy.
2. The distinction must be made between therapy visits for the purpose of the evaluation and re-evaluation and therapy visits for treatment. The distinction is documented in orders and recipient's record and billing through billing the appropriate revenue code.
3. The CMS-485 form is used to document the physician's orders and the written POC. It must include the information outlined in the therapies section of **Attachment B, Medicare-Medicaid Billing Skilled Services Billing Guide.** It must also include:
   - defined goals for each therapeutic discipline
   - specific content duration and intensity of service for each therapeutic discipline
   - delineation of whether the visit is for evaluation or treatment
   - physician recertification every 60 days as outlined in program guidelines (refer to **Section 5.1**.)
4. The evaluation visit can be done with verbal authorization from the physician. A verbal or written order documented on the CMS-485 must be obtained for services prior to the start of the treatment visits. Home Care Licensure Rules governing verbal orders must be observed for this process.

Note: All visits beyond the entry evaluation visit are considered therapeutic visits except for re-evaluation visits.

II. Prior Approval Process

The prior approval request must be initiated after the evaluation visit and as soon as the agency has a physician order for treatment visits.

DMA contracts with MRNC to handle the prior approval process for outpatient therapies. The home health agency requests prior approval by faxing the following to MRNC at the fax number listed on the form:

1. a completed prior approval request form signed by the provider
2. copies of all applicable CMS-485(s) for the current course of treatment
3. written or verbal physician order
4. a copy of each applicable evaluation and progress summary

Approved requests are for a specified number of visits within a stated time period. The approval is for only the home health agency requesting the prior approval. Additional visits or visits rendered beyond the specified time frame would require the submission of a new prior approvl request to MRNC with supporting documentation.

III. Documentation and Record Keeping

Therapy visit records must include information required under home health guidelines (see **Attachment B, Medicare-Medicaid Billing Skilled Services Billing Guide)**. In addition the records must include:

- The recipient name and MID number.
- All orders for therapy services including CMS-485 POC and supplemental written or verbal orders.
- A description of the services performed (intervention and outcome/recipient response) on each date of service signed by the person providing the service. The signature(s) must be according to the applicable standard of practice.
- A copy of each test performed or a summary listing all test results, and the written evaluation report.
- A copy of the completed prior approval form.

IV. Billing

The following revenue codes should be utilized when billing to delineate the evaluation visit from a therapy visit.

- If the purpose of a visit is the evaluation or re-evaluation of a recipient's need for therapy, the provider bills with the following revenue codes:
  424 Physical Therapy Evaluation
  434 Occupational Therapy Evaluation
  444 Speech-Language Pathology Services Evaluation

- If the purpose of a visit is treatment, the provider bills with the following revenue codes:
  420 Physical Therapy
  430 Occupational Therapy
  440 Speech-Language Pathology Services

Refer to the **Attachment B, Medicare-Medicaid Billing Skilled Services Billing Guide** for general Home Health guidelines for therapy services.

V. Contact Information

ISSUE	CONTACT
Processing of Prior Approval Forms for Specialized Therapies	MRNC Fax: 1-800-228-1437. Phone # : 1-800-228-3365 Website: http://www.MRNC.org
Obtaining Prior Approval Forms for Specialized Therapies	MRNC Website: http://www.MRNC.org
Requirements addressed in these policies for Home Health Agency Services	Division of Medical Assistance Clinical Policy/Community Care Services Section. 919/855-4260
General Home Health policy requirements and questions,	Division of Medical Assistance Clinical Policy/Community Care Services Section. 919/855-4260 DMA Website – http://www.dhhs.state.nc.us/dma
Fee Schedule for all Home Health Services	DMA Website – http://www.dhhs.state.nc.us/dma

Attachment C: Medicare-Medicaid Skilled Services Billing Guide

(This information is not an all inclusive list of covered visit types and reasons. These are only examples given for guidance)

Skilled Nursing Visits are billed using the guidelines in the table below.

SKILLED NURSING VISITS	Eligible for Medicaid Only	If recipient has MEDICARE and is:	
		Homebound	Not Homebound
A. Evaluation and Observation			
1. For initial observation and evaluation, teaching of a new diet regimen and/or compliance with new medications, and signs and symptoms of the disease state for a recipient with an acute exacerbation of a pre-existing condition that required a recent acute hospitalization.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
2. For observation and evaluation of a recipient admitted to home health because of a reasonable potential for a complication or further acute episodes for three weeks or longer. Skilled nursing coverage beyond three weeks is generally not allowed if there is no modification of treatment or initiation of additional medical procedures or evidence that abnormal or fluctuating clinical signs and symptoms are occurring.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue 581
3. For evaluation of a pre-existing condition that causes the care of a current condition to become more complex.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
4. For observation and evaluation after a period with no significant changes in intervention. The recipient's illness has reached a plateau. There is a chronic condition that is considered "stable" – no recent exacerbations, no recent changes in the medication or treatment regimen – yet there continues to be a documented medical necessity for intermittent nursing visits. **Note:** Scheduled visits are limited to no more than one visit per calendar month. One PRN visit that is properly quantified and qualified on the physician's orders may be billed between scheduled visits. When a need for intervention is identified, Medicare becomes the primary payer.	Bill Medicaid using Revenue Code550	Bill Medicaid using Revenue Code 550	Bill Medicaid using Revenue Code 550

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

SKILLED NURSING VISITS	Eligible for Medicaid Only	If recipient has MEDICARE and is:	
		Homebound	Not Homebound
B. Teaching/Training			
1. For teaching or training activities required for a recipient or the family/caregiver to manage the treatment regimen. The teaching or training is reasonable and necessary to the recipient's illness or injury.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
2. For teaching the self-administration and self-management of a specific condition such as diabetes.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
3. For reinforcement of teaching that had been provided in a controlled institutional setting. A limited number of skilled nursing visits are allowed to ensure that the recipient and the recipient's family/caregiver can transfer the teaching to a non-controlled environment.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
4. For retraining a recipient when there has been a change in procedure or in the recipient's condition that requires re-teaching; or when the recipient and/or the family/caregiver is not properly carrying out the task.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
5. For training a new caregiver.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
C. Treatment			
1. For insulin injections to a recipient who is physically and/or mentally incapable of self-administration and there is no other person willing or able to carry out the procedure.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
2. For administration of intravenous, intramuscular, or subcutaneous injections and infusions when the medication being administered is accepted as the safe and effective treatment of a recipient's illness or injury, and there is a medical reason that the medication cannot be taken orally.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
3. For providing IV antibiotic therapy to a recipient with a diagnosis of osteomyelitis.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

SKILLED NURSING VISITS	Eligible for Medicaid Only	If recipient has MEDICARE and is:	
		Homebound	Not Homebound
C. Treatment, continued			
4. For ostomy care during the post-operative period and in the presence of associated complications.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
5. For changing or replacing tubes such as indwelling Foley catheters, gastrostomy tubes, supra-pubic tubes and nasogastric tubes.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
6. For pre-filling insulin syringes if the recipient has a qualifying Medicare home health service. **Note:** Visits are limited to no more than one per calendar week.	Bill Medicaid using Revenue Code 551	**Bill Medicare**	Bill Medicaid using Revenue Code 581
7. For B-12 injections for the following conditions only: a. Pernicious anemia, megablastic anemias, macrocytic anemias, fish tapeworm anemia. b. Gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastamosis and blind loop syndrome. c. Postlateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of neuropathy due to malnutrition and alcoholism.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
8. For pre-filling insulin syringes if the recipient does not have a qualifying Medicare home health service and there is not a willing and able caregiver to do so. Visits are limited to no more than one per calendar week.	Bill Medicaid using Revenue Code 551	Bill Medicaid using Revenue Code 551	Bill Medicaid using Revenue Code 551
9. For pre-filling medication dispensers ("mediplanners") and monitoring medication compliance after a period of time when the recipient or caregiver has not been able to comprehend teaching and there is not a willing and able caregiver to do so. **Note:** Visits are limited to no more than one per calendar week.	Bill Medicaid using Revenue Code 559	Bill Medicaid using Revenue Code 559	Bill Medicaid using Revenue Code 559

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

SKILLED NURSING VISITS	Eligible for Medicaid Only	If recipient has MEDICARE and is:	
		Homebound	Not Homebound
C. Treatment, continued			
10. For administering prescribed oral medications, or providing skilled observation and monitoring the administration of eye drops when the complexity of the recipient's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a nurse to detect and evaluate side effects or reactions. **Note:** Neither Medicare nor Medicaid covers routine administration.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581
11. For "one-time" visits to provide a skilled service such as suture removal **in the absence of another qualifying skilled service**.	Bill Medicaid using Revenue Code 590	Bill Medicaid using Revenue Code 590	Bill Medicaid using Revenue Code 590
12. For venipuncture when collection of a specimen is necessary for diagnosis and treatment of a recipient's illness or injury; and when venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment. a. The physician's order for the venipuncture for a laboratory test must be associated with a specific symptom or diagnosis, and the treatment must be recognized in the PDR or other authoritative source as being reasonable and necessary for the treatment of the illness or injury. b. The frequency of testing must be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem or treatment regimen. Even when the laboratory results are consistently stable, periodic venipuncture may be reasonable and necessary because of the nature of the treatment.	Bill Medicaid using Revenue Code 580	**Bill Medicare if the recipient has a Medicare-qualifying service** Bill Medicaid in the absence of a Medicare qualifying service using Revenue Code 580	Bill Medicaid using Revenue Code 580

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

SKILLED NURSING VISITS	Eligible for Medicaid Only	If recipient has MEDICARE and is:	
		Homebound	**Not Homebound**
C. Treatment, continued			
Examples of reasonable and necessary venipuncture for stabilized recipients include, but are not limited to: • Venipuncture to monitor white blood cell count and differential count every three months for recipients taking Captopril when the results are stable and the recipient is asymptomatic. • Venipuncture for phenytoin (Dilantin) levels every three months when the results are stable and the recipient is asymptomatic. • Venipuncture to monitor complete blood count as ordered by a physician for recipients receiving chemotherapy at home. • Venipuncture for fasting blood sugar (FBS) once every two to three months for a stable diabetic. • Venipuncture for prothrombin (pro-time) monthly when the results are stable within the therapeutic range. The medical necessity for venipuncture visits that do not fall within the above must be fully substantiated in the medical records. **Note:** Medicaid may not be billed for venipuncture if the test is covered under Medicare.	Bill Medicaid using Revenue Code 580	**Bill Medicare if the recipient has a Medicare-qualifying service** Bill Medicaid in the absence of a Medicare qualifying service using Revenue Code 580	Bill Medicaid using Revenue Code 580
13. For wound care when the skills of a licensed nurse are needed to provide the care safely and effectively. The care may include direct, hands-on treatment; teaching of care; and/or skilled observation and assessment.	Bill Medicaid using Revenue Code 589	**Bill Medicare**	Bill Medicaid using Revenue Code 581

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

SKILLED NURSING VISITS	Eligible for Medicaid Only	If recipient has MEDICARE and is:	
		Homebound	Not Homebound
C. Treatment, continued			
The following characteristics generally substantiate that the skills of a licensed nurse are reasonable and necessary: a. Open wounds that are draining purulent or colored exudates, or that have a foul odor present and/or for which the recipient is receiving antibiotic therapy. b. Wounds with a drain or T-tube that requires shortening, or movement of such drains. c. Recently debrided ulcers d. Pressure sores when there is a partial tissue loss with signs of infection, or there is a full thickness tissue loss that involves exposure of fat or invasion of other tissues such as muscle or bone. e. Wounds with exposed internal vessels or a mass that may have proclivity for hemorrhage when a dressing is changed. f. Open wounds or widespread skin complications following radiation therapy, or that result from immune deficiencies or vascular insufficiencies. g. Post-operative wounds where there are complications such as infection or allergic reaction, or where there is underlying disease that has a reasonable potential to adversely affect healing. h. Third and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed. i. Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present significant risk to the recipient. j. Other open and complex wounds that require treatment that can be safely and effectively provided only by a licensed nurse.			

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

SKILLED NURSING VISITS	Eligible for Medicaid Only	If recipient has MEDICARE and is:	
		Homebound	Not Homebound
C. Treatment, continued			
Note: Although healing may not be a realistic goal, continued wound care is covered under Medicare guidelines as long as the recipient is homebound, the skilled care is needed—that is, the documentation supports reasonable potential for complications or ineffective healing—and the wound care frequency meets the intermittent criteria for Medicare coverage.			

Physical Therapy Visits are billed using the guidelines in the table below:

PHYSICAL THERAPY VISITS	Eligible for Medicaid Only	Dually Eligible Medicare and Medicaid	
		Homebound	Not Homebound
1. For recipients with conditions that will improve materially in a reasonable and generally predictable period of time.	Bill Medicaid With Revenue Code 420	Bill Medicare	You May Bill Medicaid With Revenue Code 420
2. For evaluating the overall needs, selecting the appropriate equipment and/or teaching safe transfer techniques to a recipient who has recently experienced an exacerbation of his condition that has resulted in a decreased level of functioning.	Bill Medicaid With Revenue Code 420	Bill Medicare	You May Bill Medicaid With Revenue Code 420
3. For recipients who have achieved partial restoration of function, but are not expected to achieve further measurable or functional gains; however, the recipient has a significant potential for loss of strength, endurance, range of motion/flexibility, or mobility (due to abnormal muscle tone, behavioral components or other factors) which could result in deterioration of the recipient's physical status	Bill Medicaid With Revenue Code 420	You May Bill Medicaid With Revenue Code 420	You May Bill Medicaid With Revenue Code 420
4. For establishing a maintenance program.	Bill Medicaid With Revenue Code 420	Bill Medicare	You May Bill Medicaid With Revenue Code 420

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

PHYSICAL THERAPY VISITS	Eligible for Medicaid Only	Dually Eligible Medicare and Medicaid	
		Homebound	Not Homebound
5. For gait evaluation and training for a recipient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality if the services will materially improve the recipient's ability to walk.	Bill Medicaid With Revenue Code 420	Bill Medicare	You May Bill Medicaid With Revenue Code 420
6. For exercise and functional activity program in order to maintain or retard deterioration of physical ability.	Bill Medicaid With Revenue Code 420	You May Bill Medicaid With Revenue Code 420	You May Bill Medicaid With Revenue Code 420
7. For teaching the recipient and the recipient's family/caregiver the necessary techniques, exercises and/or precautions that are reasonable and necessary to treat a recent acute episode or exacerbation of an illness or injury.	Bill Medicaid With Revenue Code 420	Bill Medicare	You May Bill Medicaid With Revenue Code 420
8. For a recipient who has been discharged from a hospital following a recent hip fracture and has an unsafe gait and restricted mobility. The recipient has not been instructed in stair climbing or in a home exercise program, and previously had a functional capacity for full mobility, ambulation and self-care	Bill Medicaid With Revenue Code 420	Bill Medicare	You May Bill Medicaid With Revenue Code 420
9. For evaluation of a pre-existing condition that causes the care of a current condition to become more complex	Bill Medicaid With Revenue Code 420	Bill Medicare	You May Bill Medicaid With Revenue Code 420
10. For maintaining range of motion as part of an active treatment program for a specific disease state, illness, or injury that has resulted in restricted mobility or when the recipient has medical complications (e.g., susceptibility to pathological fractures or soft tissue damage) which require the skills of a licensed therapist to complete range of motion exercises.	Bill Medicaid With Revenue Code 420	Bill Medicare	You May Bill Medicaid With Revenue Code 420

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

Occupational Therapy Visits are billed using the guidelines in the table below:

OCCUPATIONAL THERAPY VISITS	Eligible for Medicaid Only	Dually Eligible Medicare and Medicaid	
		Homebound	Not Homebound
1. For a dually-eligible recipient who's eligibility for MEDICARE Home Health coverage has been established by a prior need for skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period; and has a need for: • An assessment/reassessment of rehabilitation needs and potential; • The development and/or implementation of an occupational therapy program, including, but not limited to: o Selecting and teaching task oriented therapeutic activities designed to restore physical function. o Planning, implementing and supervising therapeutic tasks and activities designed to restore sensory-integrative function. o Planning, implementing and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a recipient with a diagnosed psychiatric illness. o Teaching compensatory techniques to improve the level of independence in the activities of daily living. o The designing, fabricating, and fitting of orthotic and self-help devices. • Vocational and prevocational assessment and training that is directed toward the restoration of function in the activities of daily living lost due to illness or injury (activities related solely to specific employment activities, work skills or work settings are not covered as they are not directly related to treatment).	Not Applicable see # 3 below	Bill Medicare	Not Applicable See #2 below

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

OCCUPATIONAL THERAPY VISITS	Eligible for Medicaid Only	Dually Eligible Medicare and Medicaid	
		Homebound	Not Homebound
2. For a dually-eligible recipient who needs the occupational therapy services described in 1. above, but who's eligibility for MEDICARE Home Health coverage has not been established by a prior need for skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period	Not Applicable see #3 below	You May Bill Medicaid With Revenue Code 430	You May Bill Medicaid With Revenue Code 430
3. For a Medicaid only recipient who needs the occupational therapy services described in 1, above.	Bill Medicaid With Revenue Code 430	Not Applicable	Not Applicable

Speech/Language Pathology Visits are billed using the guidelines in the table below:

SPEECH/LANGUAGE PATHOLOGY VISITS	Eligible for Medicaid Only	Dually Eligible Medicare and Medicaid	
		Homebound	Not Homebound
1. For a recipient who has a need for speech-pathology services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. Usual situations in which the coverage applies include the following: • The skills of a speech-language pathologist are required for the assessment of a recipient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders), and rehabilitation potential. • Reevaluation would only be considered reasonable and necessary if the recipient exhibited a change in functional speech or motivation, clearing of confusion or the remission of some other medical condition that previously contraindicated speech-language pathology services.	Bill Medicaid With Revenue Code 440	Bill Medicare	You May Bill Medicaid With Revenue Code 440

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

SPEECH-LANGUAGE PATHOLOGY VISITS	Eligible for Medicaid Only	Dually Eligible Medicare and Medicaid	
		Homebound	Not Homebound
• Where a recipient is undergoing restorative speech-language pathology services, routine reevaluations are considered to be a part of the therapy and could not be billed as a separate visit. • The services of a speech-language pathologist would be covered if they are needed as a result of an illness or injury and are directed towards specific speech/voice production. • Speech-language pathology would be covered where the service can only be provided by a speech-language pathologist and where it is reasonably expected that the service will materially improve the recipient's ability to independently carry out any one or combination of communicative activities of daily living in a manner that is measurably at a higher level of attainment than that prior to the initiation of the services. • The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a recipient toward speech-language communication goals in the plan of care would be covered speech-language pathology services. • The services of a speech-language pathologist to train the recipient, family or other caregivers to augment the speech-language communication treatment, or to establish an effective maintenance program would be covered speech-language pathology services. • The services of a speech-language pathologist to assist recipients with aphasia in rehabilitation of speech and language skills are covered when needed by a recipient.			

Attachment C: Medicare-Medicaid Skilled Services Billing Guide, continued

SPEECH-LANGUAGE PATHOLOGY VISITS	Eligible for Medicaid Only	Dually Eligible Medicare and Medicaid	
		Homebound	Not Homebound
2. The services of speech-language pathologist to assist recipients with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production are covered when needed by a recipient. For a recipient with dysphagia who has achieved partial restoration of function, but is not expected to experience further measurable gains from active treatment; however, the recipient has a significant potential for loss of functional swallowing resulting in deterioration of the recipient's oral intake. Visits are needed solely to review and upgrade food consistencies. Usually, the need is expected to be met within one certification period and involve no more than six visits (two to three per month in one certification period).	Bill Medicaid With Revenue Code 440	You May Bill Medicaid With Revenue Code 440	You May Bill Medicaid With Revenue Code 440
3. For a recipient with apraxia who has achieved partial restoration of function, but is not expected to experience further measurable gains from active treatment; however, the recipient has a significant potential for loss of functional communication. Visits are needed solely to review and upgrade a communication home program. Usually, the need is expected to be met within one certification period and involve no more than nine visits (one per week).	Bill Medicaid With Revenue Code 440	You May Bill Medicaid With Revenue Code 440	You May Bill Medicaid With Revenue Code 440

Attachment D: Request for Medicaid Coverage of New Home Health Supply

Medical supplies are covered under the N.C. Medicaid program as a home health service. The *Home Health Maximum Reimbursement Rate Schedule* lists the covered supplies with the corresponding HCPCS code as mandated under HIPAA. (The fee schedule is available on the DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.) Periodic updates are made to the fee schedule to accommodate coding changes made by CMS. Every effort is made to include the medical supply items that are medically necessary and reasonable to treat the illness, diseases or injuries common to the Medicaid home care population. Provisions are made to allow billing and reimbursement for items that are medically necessary for treatment but not included on the fee schedule through using miscellaneous procedure codes. The miscellaneous code used must be on the fee schedule and the supply must meet Medicaid's coverage criteria listed under **Section 3.6.1**.

If the medical supply item is not listed on the fee schedule but will need to be used on a continuous basis, a request to add the item should be submitted to DMA using the **Request for Medicaid Coverage – New Home Health Supply form** (form A001) with supporting documentation on cost, usage and efficacy.

Note: Items submitted for coverage consideration must be medically necessary for the treatment of an illness, disease condition or injury and meet all criteria for Home Health Medical Supplies outlined in **Section 3.6.1**.

REQUEST FOR MEDICAID COVERAGE
NEW HOME HEALTH SUPPLY
North Carolina
Department of Health and Human Services
DIVISION OF MEDICAL ASSISTANCE

PROVIDER NAME/ADDRESS:	Contact person		
	Phone Number		
	Provider Number		Date Submitted
1.	Name of item or supply	Manufacturer	
	Provide a brief description		
2	Does this coverage replace an existing covered item? (*circle*) YES NO		
	If yes, explain		
3	Does this coverage appear to have a potential cost savings to the Medicaid program? (*circle*) YES NO		
	If yes, explain (*example: Is it less expensive to use the packaged item?; Is there potential to alleviate an exacerbation of the patients condition?, etc)*		
4	Indications, limitations, and restrictions for use		
	a. Diagnostic indication(s).	c. Proposed advantages of the new care, service, or supply.	
	b. Duration and frequency of use.		
5	a. Procedure (CPT or HCPCS) code , if available.	c. Actual cost and source	
	b. Estimates of charges for the requested coverage		
6	Does Medicare and/or other insurance company cover this? (*circle*) YES NO (Attach verification, if available)		
7	Extent to which the requested coverage is currently in use in North Carolina.		
8	Attach any Supporting data from research studies, peer review journals etc. Attachments? (*circle*) YES NO		

Submit completed form with attachments to Hospice/Home Health Consultant, DMA Clinical Policy and Programs, 2501 Mail Service Center, Raleigh, NC 27699-2501

Form A001
10/04